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July 19, 2013

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9957-P
P.O. Box 8010
Baltimore, Maryland 21244-8010

Re: CMS-9957-P, Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards

Dear Administrator Tavenner:

The Silver State Health Insurance Exchange appreciates the opportunity to comment on proposed rule CMS-9957-P published in the Federal Register on June 19, 2013¹ regarding Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards. The proposed rule is based on sections 2701, 2702, 2703, 2723 of the Public Health Services Act and sections 1311, 1312, 1313, 1321, 1341, 1342, 1343, 1401, 1402, 1411 and 1412 of the Affordable Care Act (ACA).

The proposed rule sets forth financial integrity and oversight standards with respect to Exchanges, Qualified Health Plan (QHP) issuers in Federally Facilitated Exchanges (FFE) and States with regard to the operation of risk adjustment and reinsurance programs. It also proposes additional standards with respect to agents and brokers. These standards include financial integrity provisions and protections against fraud and abuse. We appreciate the objectives of the proposed rule and request consideration of the following comments.

45 CFR § 155.280 OVERSIGHT AND MONITORING OF PRIVACY AND SECURITY REQUIREMENTS

The proposed rule at 45 CFR § 155.280 provides standards for the monitoring and reporting of security breaches. We recognize that data security is vital to the reputation and sustainability of the Exchange. However, we are concerned about the time frames proposed to report a security breach and the potentially overly broad reach of this rule to other non-Exchange entities.

Specifically, 45 CFR § 155.280(c)(ii)(3) requires:

Federally-facilitated Exchanges, non-Exchange entities associated with the Federally-facilitated Exchange, and State Exchanges must report all privacy and security incidents and breaches to HHS within one (1) hour of discovering the incident or breach. A non-Exchange entity associated with a

¹ [CMS-9957-P](#) Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards (Federal Register, Vol. 78, No. 118, Wednesday, June 19, 2013, Proposed Rules, pp. 37032-37095).

State Exchange must report all privacy and security incidents and breaches to the State Exchange with which they are associated.

We are concerned that the one hour requirement may be difficult to administer. First, when does the one hour clock start? Often it is difficult to recognize that a breach has occurred and the incident must be researched before a breach is confirmed. We recommend that “discovering the incident or breach” be defined as “reported to the Information Security Officer of the State Exchange.” Once the incident has been properly categorized and reported to the Exchange’s Information Security Officer, notification within one hour is not necessarily unreasonable. However, if Nevada Health Link recognizes and reports a breach within an hour at the close of business Pacific Standard Time, will there be staff available at HHS to accept the report after normal business hours?

What is the definition of “report?” We would be unable to provide a proper mitigation report within an hour. We could provide a simple email notification to HHS staff of a suspected breach within an hour. However, we are concerned that the one hour deadline would create many false alarms as entities rush to comply with the one hour deadline but do not have time to properly investigate each incident before the incident is reported. We propose that the guidance be worded to notify CMS following the discovery or notification of a breach in the most expedient time possible and without unreasonable delay.

What is the definition of “non-Exchange entity?” While not specifically defined in regulation or the preamble, it appears to describe brokers, agents, navigators, enrollment assisters and certified application counselors. However, it could also include the agency overseeing Medicaid and CHIP and could include QHP issuers. The Exchange has no authority over Medicaid and CHIP. While it is important to know whether QHP issuers have a data breach, member notification and notification to federal agencies should be the responsibility of the QHP issuer and should not be funneled through the Exchange. Notification to the Exchange could be provided within a month during the monthly reporting cycle. Other than revoking login privileges for Nevada Health Link, the Exchange has no regulatory control over agents, brokers and certified application counselors and reporting of data breaches to consumers and to federal agencies is their responsibility. Assuming a non-Exchange entity identifies a breach, would they be required to report the breach to the Exchange within an hour?

45 CFR §§ 155.340(h) & 156.460(c) REFUNDS TO ENROLLEES FOR IMPROPER REDUCTION OF APTC

We support the concept provided in the proposed rule at 45 CFR §§ 155.340(h) & 156.460(c) which requires the Exchange or QHP issuer to either (1) reduce the next month’s premium by the excess amount of APTC paid due to improper allocation by the Exchange or QHP issuer or (2) to refund to the enrollee the excess amount of APTC paid due to improper allocation by the Exchange or QHP issuer. However, we would appreciate consideration to add flexibility for the benefit of the consumer and additional protection for the consumer if the Exchange or QHP issuer does not charge enough (calculates APTC that is too small).

First, a consumer may wish to accept repayment of the excess amount of APTC through reductions to premium over the remainder of the calendar year. This option would save the consumer time cashing a check. Furthermore, an individual who is not expecting to receive a check in the mail may accidentally throw out the check and cashing a check may be difficult for the unbanked population considered in 45 CFR § 156.1240(a)(2). Finally, this option, if selected by the consumer, would reduce administrative costs for the Exchange and carrier.

Second, consumers with flexible incomes or who expect to receive bonuses at the end of the year may choose to reduce the amount of APTC used to reduce premium so that they do not have an unexpected tax liability at the end of the tax year. The proposed rule does not appear to provide flexibility to allow the consumer to choose to reduce that refund in favor of a reduced tax liability.

Finally, if the Exchange or QHP issuer charges a premium that is too small due to incorrectly calculating an APTC that is too large, the consumer may have an increased tax liability. The Exchange or QHP issuer has a responsibility to inform the consumer of the incorrect APTC calculation, regardless of whether the incorrectly calculated APTC is too high or too small.

Therefore, we recommend the proposed rule at 45 CFR § 155.340(h) be reworded as follows (substitute “Exchange” with “QHP issuer” for 45 CFR § 156.460(c)):

If the Exchange discovers that it did not reduce an enrollee’s premium by the amount of the advance payment of the premium tax credit *or the amount of the advance payment of the premium tax credit elected to be received by the enrollee*, then the Exchange must ~~refund to the enrollee any excess premium paid by or for the enrollee and~~ notify the enrollee of the improper reduction no later than 30 calendar days after discovery of the improper reduction *and*:

- (1) If a refund is requested by the enrollee, refund to the enrollee any excess premium paid by or for the enrollee;*
- (2) If a refund is not requested and the amount of the excess premium paid by or for the enrollee is greater than the enrollee’s portion of the premium for the remainder of the calendar year, refund to the enrollee any premium paid in excess of the portion of the premium due for the remainder of the year;*
- (3) If a refund is not requested or due, reduce the enrollee’s portion of the premium for the remainder of the calendar year by the amount of any excess premium paid by or for the enrollee; or*
- (4) If the amount of the reduction of the enrollee’s premium would result in the enrollee owing more than \$600 more than would otherwise be available to the enrollee in premium tax credits, the enrollee may elect to increase the enrollee’s portion of premium.*

45 CFR § 156.410 COST SHARING REDUCTIONS FOR ENROLLEES

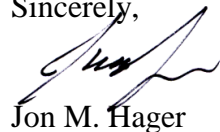
The proposed rule at 45 CFR § 156.410 requires carriers to refund individuals for improper allocation of cost sharing reductions and does not allow carriers to recoup funds expended in error due improper cost sharing reduction allocation. It is recognized that 156.410(b) indicates the carrier will assign an individual to the proper silver plan variation or American Indian zero cost plan. However, in practicality, it is the Exchange that will do so. To ensure that consumers are not confused by the plans available to them, Nevada Health Link was designed to show only

the silver plan variations (or American Indian plan) for which they qualify. When an individual selects that plan, Nevada Health Link sends enrollment information to the carrier indicating the individual has enrolled in that plan. In fact, the carrier is not set up to place the individual in the correct plan unless the Exchange has indicated the appropriate plan. Though we do not anticipate incorrect assignments, Nevada Health Link could enroll an individual in the incorrect cost sharing reduction plan and the carrier would have no say. In this situation, the Exchange is not set up to pay any portion of cost sharing reduction on the enrollee's behalf and the carrier is not at fault for the improper assignment.

Carriers often improperly adjudicate claims for a variety of reasons. If a carrier incorrectly adjudicates a claim, would this be considered incorrect cost sharing for which the carrier could not be reimbursed? If a carrier incorrectly adjudicates a claim or applies incorrect cost sharing, should the carrier be allowed to reimburse or collect the difference over the course of the plan year?

We appreciate the opportunity to offer these comments and look forward to working with you further on these and other health insurance exchange implementation activities. Thank you very much for considering our input.

Sincerely,



Jon M. Hager
Executive Director, Silver State Health Insurance Exchange

cc: Jackie Bryant, Deputy Chief of Staff, Office of the Governor
Barbara Smith Campbell, Silver State Health Insurance Exchange Board Chair
Mike Willden, Director, Department of Health and Human Services
Scott Kipper, Commissioner of Insurance, Division of Insurance
Gary Cohen, Director, Center for Consumer Information and Insurance Oversight
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